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ABSTRACT

An 18-year old's freshman year in college is not only a test of his or her intellect, but also a test in social skills, adaptability to new living situations, and other conditions. This study examined the link of emotions to compulsive eating and its use as a coping mechanism for female college students. It explores the stresses of the transition from high school to college and how a breakdown in coping skills can lead to the development of an eating disorder. Twenty-nine resident freshmen females, averaging 18.5 years of age, responded to the survey. Results showed that 76 percent of the respondents had experienced a binge. Their average weight gain over a seven-month period was 4.34 pounds. Fifty-nine percent had changed their eating patterns since moving on campus. Seventy-nine percent gained from 2 to 20 pounds. Supporting the notion that binges are linked to emotion, the feelings respondents described prior to a binge included stress, boredom, and hunger. During a binge they felt relaxed, happy, and bored, while post-binge feelings included anger, depression, and sickness. The high incidence of disordered eating behaviors, distorted attitudes, and poor coping mechanisms, underline the importance of educating students about healthy eating. (RJM)

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COMPULSIVE EATING: THE EMOTIONAL LINK OF ITS USE AS A COPING
MECHANISM FOR RESIDENT FRESHMAN FEMALE COLLEGE STUDENTS

A Thesis

Presented to the Faculty of the Graduate School of Education,
Department of Special Education and Counseling
of William Paterson College
in Partial Fulfillment of the Requirements for
the Degree of Master of Education

by

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May 1993

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Abstract

This study was constructed to examine the link of emotions to compulsive eating and its use as a coping mechanism for resident college freshman female college students. It explores the stresses of the transition from high school to college and how a breakdown in coping skills can lead to the development of an eating disorder. There were 29 respondents to a survey from four New Jersey colleges. All were resident freshmen females averaging 18.5 years of age. This study found that 76% of the respondents experienced a binge. Their average weight gain over a seven month period was 4.34 pounds. Fifty-nine percent changed their eating patterns since moving on campus. Seventy-nine percent gained anywhere between 2 - 20 pounds. Bingeing is linked with emotion. The emotions felt by respondents of this study in descending order of predominance before a binge was stress, boredom, and hunger; during a binge they felt relaxed, happy and bored. Feelings after a binge were anger, depression, and sickness. Further research has been recommended.

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Chapter 1

Introduction

The transition made from high school to college can be traumatic. Where some may view their next step towards adulthood as an opportunity to expand their horizon, specialize in their chosen field or improve their status in life, others may find it difficult to meet the challenges and expectations made of them. An 18 year old's freshman year in college is not only a test of his or her intellect, but also a test in social skills, adaptability to new living situations, as well as, attracting the opposite sex.

Different students cope with their transition in different ways. Sometimes the unaccustomed freedom and responsibility of college life leads to changes in eating patterns formerly set by family routine. Academic pressure, dating, relationships, conformity to the "in" group all lead to the questioning of self-concept which can result in lack of self-esteem. These components are all linked to the disruption of eating patterns and an excessive concern with body image (Hesse-Biber & Marino, 1991).

This study will deal with resident freshman female college students and their use of compulsive eating as a

coping mechanism. Food can be a front for dealing with emotions, particularly stress and boredom.

Statement of the Problem

The purpose of this study is to determine which emotions are most commonly linked with compulsive eating (bingeing) behaviors and how they are used as a coping mechanism for resident freshman female college students, particularly when dealing with stress.

Hypotheses

1. Many residents female college students have experienced a binge.
2. Eating patterns change for these students from their high school, home environment to residing on campus.
3. Most resident freshmen females gain weight their first year.
4. Bingeing is linked to emotion.
5. The predominant emotion preceding a binge is stress.
6. Most use bingeing as a form of relaxation.
7. The predominant emotion following a binge is generally negative.
8. Bingeing occurs most often late at night.

9. Women do not enjoy bingeing.
10. Smoking is linked to compulsive eating.

Purpose of the Study

The purpose of this study is to determine the situations which contribute to compulsive eating (bingeing) behavior in college freshmen women who live on campus and how it is linked with emotions, particularly stress.

Importance of the Problem

Twenty million women have eating disorders (Roth, 1991). Obesity is the number one eating disorder in the United States and is medically defined as weighing 20 percent over an individual's ideal weight (Landau, 1991). Thirty percent of the U.S. adult population is considered obese (Saunders, 1985). Compulsive overeating, a subgroup of bulimia, leads to obesity. Bulimia and binge eating is rapidly becoming the women's psychological disease of our time, rivaling depression in its prevalence. The evidence is that bulimia and binge eating is quite prevalent particularly on college campuses (Crandall, 1988). Studies have shown that as many as 60% of college age women develop some bulimic symptoms, such as compulsive overeating. Though not all these women go on to develop severe chronic bulimia (Rich & Bonner, 1987), estimates suggest 4-15% of college women have serious problems

with bulimia (Crandall, 1988). The issues of compulsive eating must be addressed in order to ensure a healthier nation.

Definition of Terms

- Binge - Eating large quantities of high caloric foods when not physically hungry, usually accompanied by a sense of feeling out of control.
- Bulimia - see Appendix B for Diagnostic Criteria for Bulimia.
- Freshman - first year college student; average age is 18.5.
- Non-purger - one who does not compensate for bingeing by purging (see purge).
- Normal Eating Pattern - eating three meals a day consistently. According to the U. S. Surgeon General, a normal healthy diet consists of two fruits, one high in vitamin C; three vegetables, one high in vitamin A; four grains, one being a whole grain; six servings of protein; 16 oz of milk; and a limited amount of fat.

Purge -

the use of self-induced vomiting, laxatives, diuretics, fasting or excessive exercise in an attempt to prevent weight gain from an inordinately high caloric intake or to promote weight loss.

Restrained Eater -

(or chronic dieter) - severely restricting caloric intake in an attempt to lose weight. It usually implies a pattern alternating between consciously limiting food consumption and violating the "diet".

Resident -

a college student who lives in a dormitory on campus.

Chapter 2

Review of Related Literature

Over the past three decades, increased awareness has risen about the high incidence of eating disorders, primarily among women, and particularly, female college students. Anorexia nervosa was exposed in the 1960s, bulimia exploded in the late seventies and early 1980s, and just recently compulsive overeating, a sub-group of bulimia, has started getting a great deal of attention.

Compulsive overeating is a reaction to difficult situations and is used as a coping mechanism to deal with emotions, particularly stress. The transition from high school to college can be a particularly stressful experience. A sizeable number of freshmen experience leaving home for the first college semester as traumatic. Their unrecognized and continued dependency on parents and their lack of experience in exerting personal power with decision making and with increasingly mature emotional demands for self-reliance suggest potential problems in living and functioning in the more independent, less controlled college environment (Dickstein, 1989).

Entrance into college involves transitions in personal

development, separation from family, development of new interpersonal relationships, examination of values and acceptance of new responsibilities. Some students find this transition to be an exciting new challenge towards personal growth. Others find these changes overwhelming, which results in experiencing emotional maladjustment and depression (Johnson & Connors, 1987).

Emotional maladjustment, breakdown in healthy coping mechanisms and depression are strongly linked to eating disorders. This knowledge has prompted many health professionals, parents and teachers to wonder if the college setting itself might, in some cases, foster, facilitate, support or even provoke the development of eating disorders (Dickstein, 1989).

There is evidence that individuals who are psychologically vulnerable to developing eating disorders have difficulty with adapting to changes in life-style. Because the majority of these students are away from home for the first time, it is possible that residence hall living is a situation that could serve as a catalyst for the development of an eating disorder or a situation that could exacerbate an existing eating problem (Berg, 1988).

Transition and change are characteristic of life and yet

are likely to result in stressful episodes sometimes creating psychological disturbances and physical ill health. Although the transition is assumed to be a positive upwardly mobile feature of life, a study conducted by Fisher & Hood (1987) reported a number of indications of increased mental disturbances following the transition of students (Fisher & Hood, 1988).

One of the major issues borne out of transition is coping with stress. A study conducted by Koplick and DeVito (1986) compared the freshmen class of 1976 to the class of 1986. Their results concluded that freshmen college students seemed to be more troubled in '86 than ten years prior. They found that there seemed to be an increase in reported distresses by college students in every aspect of their lives, including controlling their weight.

University students may feel that the "education process" places them in stressful situations. Stress has numerous symptoms and is a definable condition in which adaptive responses are made to demands or the adaptive conditions of the unsatisfied needs. Stress may lead to behavioral or physiological symptoms that may change activities of everyday functions. Stress also is a reaction to both external and internal stimuli. One such adaptive response is food

consumption (Spillman, 1990).

Effective coping skills are essential for healthy cognitive and behavioral development. People with good coping styles generally try to deal directly with the stressor, such as thinking of a positive alternative. They can also employ behavioral or cognitive activities, like exercising or trying to see the good side of a given situation which, in turn, may help to maintain a sense of well-being and optimism. People with less effective coping skills may tend to use a more avoidant or immature coping style such as self-blame, reacting in a hostile manner towards others, substance abuse, or compulsive behaviors. These are activities that may actually have an adverse impact on stressful situations (Jorgensen & Dusek, 1990).

It has been proposed that eating-disordered persons have poor coping skills and that eating may be a reflection of maladaptive coping skills. Therefore, it has been speculated that eating-disordered individuals would have poorer coping skills than individuals without eating disorders (Soukup, Beiler & Terrell, 1990).

Erik Erikson theorized that development proceeds through a series of psychosocial crises or stages. Optimal resolution of the crises is related to greater feelings of self control,

confidence in one's abilities, trust in others, personal control over life's events and the like. Those who more optimally resolve psychosocial crises, then, may be more prone to employing coping styles that help maintain a sense of well being and optimism when confronted by stressors (Jorgensen & Dusek, 1990).

According to Garfinkel & Garner (1982), a major group of precipitants to the development of eating disorders are circumstances in which new demands or expectations confront the individual. These demands may also occur following separations (Berg, 1988).

Early investigators proposed that in addition to the increased physiological and psychological adaptational demands on individuals, especially college freshmen, an excessive amount of stress-provoking events renders certain individuals vulnerable to the development of an eating pathology. Previous research did indeed indicate that stress is related to maladaptive eating habits among both animals and humans. Recently it has been proposed that bulimia and perhaps other forms of eating disorders may be due at least in part to different cognitive styles. This model theorizes that an individual's perception and capacity to cope with stress mediate the relationship between stress and eating disorders.

(Soukup, Beiler, & Terrell, 1990)

In addition to eating-disordered individuals perceiving themselves as being exposed to excessive stress, others have proposed that these individuals are at risk in reducing their stress coping level because of poor problem-solving ability. Deficit in coping skills or general problem-solving inadequacies may render eating disordered individuals less able to deal effectively with stress that the eating disorder may be a manifestation of maladaptive coping styles (Soukup, Beiler & Terrell, 1990).

In a study conducted by Spillman (1990) of a total of 250 women surveyed 129 reportedly alleviate stress by altering their eating habits. Of the women 92 reported consuming more food while under stress, and 37 reported consuming less food during stress. This statistic is second only to the use of exercise to alleviate stress. Women consumed soft drinks and candy/sweets (especially chocolate) more often or in greater quantities when under stress.

Critical analysis of the college environment and the college experience reveals many factors that can potentiate or exacerbate eating related problems. One of the major issues seems to involve coping with stress, with reports of poor coping in the present (including the binge-purge behaviors and

the obsessive cognitions) and fears about coping in the future; such negative appraisals and coping deficits are characteristic of bulimics (Klemchuk, Hutchinson, & Frank, 1990).

Our culture has conflicting views of eating. On one hand, we worship thinness and are constantly confronted with the images of slender men and women. Weight loss is a multi-million dollar business. Stores are filled with the latest diet books and low calorie foods and drinks, sporting shops overflow with exercise equipment, and health spas and fitness centers dot the landscape. On the other hand, we are constantly encouraged to eat - by commercials on television, mouth watering ads in magazines, vending machines in every office, convenience food stores at every corner. Thus it comes to no surprise that millions of Americans have lost control of their eating. One of the growing responses to these competing pressures is bulimia (Saunders, 1985).

Binge eating among college women may range from 23% to nearly 85% (Hesse-Biber & Marino, 1991). Student populations have been surveyed in many other studies and binge eating is always reported as a fairly common behavior among the female students (Wardle, 1987). Binge eating is a central feature of bulimic behavior. Bulimia means "ox appetite". The rapid

and uncontrollable consumption of high-caloric foods (bingeing), may or may not be controlled by purging, usually self-induced vomiting (Saunders, 1985).

The Diagnostic and Statistical Manual of Mental Disorders III (DSM III) defines bulimia as "recurrent episodes of binge eating accompanied by an awareness that the eating pattern is abnormal, fear of not being able to stop eating voluntarily, and depressed mood and self-deprecating thoughts following the eating binges."

The disorder includes at least three of the following eating behaviors:

1. Consumption of high caloric, easily ingested food during a binge,
2. Inconspicuous eating during a binge,
3. termination of such eating episodes by abdominal pain, sleep, social interruption or self-induced vomiting,
4. Repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or the use of cathartics or diuretics,
5. Continued weight fluctuations greater than ten pounds as the result of alternating binges and fasts (The American Psychiatric Association, 1980).

As the societal pressure on young women increase, the enigma of bulimia has surfaced. Although this syndrome has been reported with disturbing frequency in college-age females, it was not classified as a distinct psychiatric disorder until 1980 (Jones, 1989).

Bulimia occurs most often in women who are in their late teens or early adulthood. People with bulimia are typically near normal weight and healthy in appearance, though some may have a distorted image of their bodies. Food, weight and dieting are extremely important to them. About one third are mildly overweight before the onset of illness. Bulimics tend to be emotionally insecure, frightened, and lonely people; they feel inadequate in their relationships with others. Binge eating and purging may be an attempt to escape these feelings. Many bulimics are "model children" who have underlying low self-esteem (Jones, 1989).

Bulimics are usually white, middle or upper middle class women who are bright, achievement oriented and perfectionistic. They lack self-esteem, are not assertive and feel generally ineffective, which combined with their perfectionism, often leads to depression. Their secret shameful activity isolates and alienates them (Saunders, 1985).

The studies cited throughout compiled research provide an overall impression that their prevalence is high among women in higher education. The exact incidence of bulimia is particularly difficult to determine because of the secretive nature of the disorder and because the bulimic's weight is

typically within normal limits (Berg, 1988).

Eating disorders such as bulimia, frequently begin in early adolescence and are alarmingly common on college campuses and are thought to be increasing in our society, particularly in women (Christiansen, Payne, & Van Valkenburg, 1986).

Bulimics have a tremendous desire to please others and base their sense of self-worth on the approval of others. Since they gain their sense of self-worth through others, they become overly dependent on others, which creates a self-perpetuating pattern of rejection (Thelen, Farmer, McLaughlin, & Pruitt, 1990).

The three personality features that are consistently noted in bulimic patients are self-regulatory problems, social discomfort and sensitivity to rejection and high achievement expectations for which the pursuit of thinness becomes a vehicle of expression (Wardle, 1987).

Depression is also linked with bulimia. It is true that 40 to 80% of eating disordered patients meet criteria for a lifetime history of major depression. (Wardle, 1987)

Perfectionism is an aspect of bulimia that is not listed in the DSM III criteria but has been frequently discussed in the literature as a pervasive characteristic associated with

this disorder. Another general characteristic of perfectionism is dichotomous , all-or-nothing thinking. In the mind of a perfectionist, only extremes of a continuum exist; there is no middle ground (Brouwers & Wiggum, 1993).

Bulimics are often attractive, intelligent individuals who suffer from low self-esteem and frequently need others' affirmation to feel worth while. Researchers have found that bulimia frequently surfaces after a significant life change like going off to college or other such events (Landau, 1991).

Regular binge eating followed by self-induced vomiting, though not socially sanctioned, is a familiar concept to most young women today. In contrast, the general population had little exposure to bulimia 30 years ago (and indeed, bulimia was not recognized as a syndrome even in medical literature until the 1940s) (McCann, Rossiter, King, & Agras, 1991).

Initially, research on the treatment of bulimia was conducted in hospitals, where the condition was viewed as a variant of anorexia nervosa. Although this research was valuable, it was often misleading because it was done on inpatients. Since bulimia has only been recently recognized as a separate disorder (1980), its treatment history is brief.

"Lack of control is the hallmark of bulimia" (Saunders, 1985). Typical binges have been described at length in the literature and the media, but there are significant variations in what constitutes a binge. Some clinical psychologists describe binges as eating episodes in which from 1,200 to 11,500 calories are taken in; the average intake is 3,500 calories. Binges of up to 50,000 calories have been reported. Binges involving enormous quantities of high-calorie foods are most often described: a typical example is a woman who eats one-half gallon of ice cream, one dozen donuts, a pizza and part of a cake - all washed down with a six pack of soft drinks. This kind of binge does occur, most often among purgers. For bulimics who vomit, the emphasis is on such foods as uncooked cake mix that can be easily regurgitated (Saunders, 1985).

Purging is defined as self-induced vomiting or the use of laxatives or more rarely, the use of diuretics in an attempt to prevent weight gain from excessive caloric intake or to promote weight loss. Even more broadly defined, excessive exercise and fasting can also be seen as a form of purging (Saunders, 1985).

Another possible subtype of bulimia, referred to here as non-purging bulimia, includes those individuals who meet the

DSM-III criteria for bulimia nervosa, but do not engage in self-induced vomiting or laxative abuse (McCann, Rossiter, King, & Agras, 1991).

The non-purger is the "sister" of the purger, who has lost control over eating, but who does not purge - either because she is unable to make herself do so or because she has simply not thought of it. This compulsive eater has tried every diet, possesses a library of "how-to" books, knows the caloric value of every food, and has probably lost hundreds of pounds over the years on various diets. She alternates between convincing herself that she does not mind being fat and being disgusted with her appearance and her lack of self control. She wears her weakness for all to see (Saunders, 1985).

Although bulimia is defined in DSM III, the criteria are somewhat vague. What constitutes a binge is not specified. Bulimics come in all shapes and sizes with varying degrees of severity. For many, the term compulsive eater may be a more accurate description of the problem. It may be that obese bulimics are less often seen by mental health professionals, going instead to professionals who specialize in obesity or weight loss (Saunders, 1985).

Although some issues may be different for the women who

purge, both the purger and non-purger share a lack of control over eating behavior and both meet DSM III criteria for bulimia. "Many overeaters resemble bulimics [purgers] not just in their eating, which they may use to cope, but also in their interest in why they overeat, their discouragement about stopping their binges, their desire for a magic cure that does not require them to change" (Cauwells, 1983, p. 37).

Usually, those who purge are younger and perhaps single or without children; those who do not purge tend to be older and have other family responsibilities. Although these differences may affect the patient's particular strategies, the process is similar for all patients (Saunders, 1985).

The food consumed during a binge often has high caloric content, a sweet taste and a texture that facilitate rapid eating. Ice cream is an example of one of those foods. The food, which is eaten as inconspicuously as possible or secretly, is ingested with little chewing. Often there is a feeling of loss of control or inability to stop eating (Jones, 1989).

Although bingeing varies, there seems to be common preoccupation with junk food. During a binge, the compulsive eater reports eating any available food. A binge lasts an average of 1.2 hours, although it can range from 15 minutes to

8 hours. In most cases, eating is accelerated and the person is unaware of how the food tastes (Saunders, 1985).

In a study conducted by Rand & Kuldau (1991) involving restrained and non-restrained eaters they found that binge eating indicates a breakdown of rigid dietary restrictions and/or can be a symptom of an eating disorder. Although the majority of restrained eaters who reported binge eating in this study did not have an eating disorder, the presence of binge eating in conjunction with restrained eating appeared to increase the probability of clinically significant eating disorders. In this study, almost one third of the restrained eaters who admitted binge eating were also classified as having bulimia or bulimia related atypical eating disorders and over two thirds of the eating disorder cases were classified as restrained eaters (Rand & Kuldau, 1991). As the name implies, restrained eating refers to the tendency to restrict food intake in order to control body weight (Stunkard & Wadden, 1990).

In many cases, the overeating may be a paradoxical consequence of attempts at caloric restriction, including dieting. Losing weight is the most common motivation behind dieting, yet diets are rarely successful at achieving lasting weight loss. Many diets fail because occasional bouts of

uninhibited eating cancel out efforts of caloric restriction (Heatherton & Baumeister, 1991). Diets don't work. Restrictive eating only leads to biological cravings for essential nutrients and caloric needs. The individual feels like a failure for not sticking to their diet, leading them to a binge situation (Roth, 1991).

Sometimes researchers use the term binge eating to refer to eating that results from disinhibition of dietary restraints, regardless of whether it is part of a broader pattern of bulimia. Individuals who undertake restrictive diets have been shown to engage in uninhibited eating under a wide variety of circumstances. The characteristic behavioral and personality traits of chronic dieters are in many cases similar to those of bulimics. (Heatherton & Baumeister, 1991).

Unfortunately dieting often leads to hunger and cravings for sweet rich food. Then overeating begins as a reaction to some type of stress, anxiety, depression, anger, frustration or loneliness. Food is perceived as comfort, an antidote for emotional pain and a relief from hunger (Jones, 1989).

A rigid diet results in a painful state of deprivation. Eventually they can no longer resist and they begin to binge. The purging is in response to the guilt and anxiety over

gorging (Yates, 1989). Compulsive eating, contrasting itself, stems from adherence to the prevailing medical and cultural ideals of thinness (Wardle, 1987).

The binge/purge phenomenon is cyclical. Typically a binge is larger than a normal meal, and afterwards patients report low mood, self-criticism and guilt. When the binge episode is over patients usually strengthen their resolve to control their food intake more successfully in the future. If circumstances are right, these good intentions, however, in the face of depression, temptation or other conditions which sap motivational strength and control is abandoned again before long. Essentially a cycle of abstention/craving/loss of control/renewed resolution characterizes the problem of compulsive eating (Wardle, 1987).

Compulsive eating is therefore best understood in terms of a conflict between a biologically derived drive for food and a culturally derived drive for thinness (Wardle, 1987). The emphasis on dieting among young women creates a "deprivation mentality" where self-esteem becomes equated to how well one is doing in controlling food intake. Effectiveness comes to represent the ability to control oneself rather than express oneself (Morgan, Affleck, & Solloway, 1991). Those who are most self-conscious and

self-critical are the adolescents. For girls growing up there is constant competitive slimming. Slimness today equate with self-control, elegance, sexual attractiveness and youth (Dally & Gomez, 1980).

The preponderance of evidence suggests that eating disorders result from, or tend to be maintained by, not only biological, personality, and cognitive variables, but by cultural values as well (Soukup, Beiler, & Terrell, 1990). Culturally, in American society, a women's sense of worth may often depend upon her ability to attract a man. Social status is determined largely by income and occupation for men, access to social status is generally direct. However, several researchers suggest that women are socialized in the American culture to rely on their "natural" resources - beauty, charm, and nurturance - to indirectly gain access, through marriage to higher social status. As a result, the stakes of physical attractiveness for women are high. Appearance is a strong selective factor for social success and body weight is a significant factor in physical attraction (Hesse-Biber, Clayton-Matthews, & Downey, 1987).

The high degree of body dissatisfaction among college women is striking and disturbing and it is strongly linked to eating disorders (Klemchuk, Hutchinson, & Frank, 1990).

Weight is an important, if not the predominant aspect of body image. Increasingly, Western ideals of beauty and physical attraction appear to be related to thinness. From an analysis of popular culture, a substantial amount of evidence suggests an increasingly thinner beauty ideal for women. It is ironic that the downward shift in women's ideal weight comes at a time when the average women under the age of 30 has become heavier over the last two decades. Researchers suggest that weight and body image constitute central factors in a women's sense of identity. (Hesse-Biber, Clayton-Matthews, & Downey, 1987).

Crandall (1988), through his extensive research with college sorority members, argues that social pressures in friendship groups are important mechanisms by which binge eating is acquired and spread. Social groups develop social norms about what is appropriate behavior for their members. If eating, dieting and losing weight are important to the members, then norms will arise in the group defining how much, when and with whom. People are very motivated to imitate or model attitudes or behaviors that are important, characteristic or definitional to the social group. The more important the social group and the more central a behavior is to a group, the greater the pressure toward uniformity and the

more likely that members of the group will imitate each others' behavior. If binge eating is an important or meaningful behavior to a social group, then over time within groups, peoples' binge-eating patterns should grow more similar. Crandall also suggests that when a woman experiences distress, she is open to social influence. When the influence she is receiving in terms of social information and approval is in support of bingeing, she is more likely to become a binge eater (Crandall, 1988).

For an intelligent woman today the transition to college can be more daunting than ever before. She is expected to work hard, achieve success and to do as well as her brother in the academic sphere. At the same time she has to cope with her femininity, keep her end up with her friends by attaining some measure of sexual and social success and adapt to new emotional needs and demands. Some women still sense a contradiction between academic success and femininity, with some justification. Some men are unattracted by intelligent, bright women, however pretty they may be. By dieting and losing weight or by developing compulsive eating behaviors and adding on pounds, they can virtually revert to childhood status, sexual feelings fade or are blocked, menstruation may stop and they withdraw into their safe shell by being either

under or overweight. They may still continue their studies, but without the strain of social and sexual pressure. Why are young women who develop anorexia nervosa or exhibit compulsive eating behaviors invariably intelligent and nearly always attractive? Precisely because much more is expected of them in both fields. The strains are too much. As mentioned earlier, such young women usually come from families of high attainment so that expectations are high whether spoken or silent (Dally & Gomez, 1980).

In their research Heatherton & Baumeister (1991) developed their escape theory of binge eating. The central hypothesis of their theory is that binge eating may arise as part of a motivated attempt to escape from self-awareness. The motivation to escape from self-awareness begins with a comparison of self against high standards or ideals. The higher the standards, the greater the likelihood of the failure. A first prediction, therefore, is that binge eaters will be characterized by unusually high standards, including goals, perceived expectations, and ideals. These may refer specifically to expectations for body thinness, or they may encompass more general expectations for success, achievement, virtue and popularity. They may also be either the person's own inner standards or the ones held by peer or adult social

groups. Either way, the binge eater will feel that it will be difficult to live up to these standards. The awareness of her "self's" shortcomings then creates negative affect, such as anxiety or depression. Eating binges should therefore occur during or following a period of negative affect and unhappy moods, which are brought on by the comparison of self against standards (Heatherton & Baumeister, 1991).

Although the escape theory of binge eating emphasizes the relevant standards of dieting and slimness, any high standards could conceivably give rise to escapist motivations and binge eating. Some evidence does suggest that binge eating can result from high standards that are not directly related to thinness. Thus, bulimia occurs with the greatest frequency among high-achieving women (Heatherton & Baumeister, 1991).

Although modern culture has a powerful fascination with the individual "self," this fascination can compound subjective stress when the person regards herself as unattractive, incompetent, or unsuitable. Such a poor sense of "self" may provoke a powerful set of motivations to escape from this awareness. This desire to escape from "self" may provide a useful framework for making sense of the paradoxical pattern of binge eating (Heatherton & Baumeister, 1991).

Geneen Roth (1984), author of Breaking Free From Compulsive Eating, says:

Bingeing is an attitude, bingeing is qualitative. As with any symptom, the root causes must be acknowledged and to some extent, dealt with before the symptom will disappear. Bingeing is not only the act of eating and its concomitant feelings, but all the moments, decisions and feelings that lead up to the fact. Bingeing is a symptom, once it happens it becomes a problem in itself, but it is foremost a symptom - a symptom that decisions, feelings and attitudes about yourself, your relationships, and food that precede the onset of the binge are not serving you. Bingeing is only the tip of the iceberg (p. 76).

The binge itself can be an intensely pleasurable experience, with its anticipation even more satisfying than the actual act. The elaborate preparations for the binge may be pleasant and compulsive eaters, totally preoccupied in the midst of a binge, are unaware of their feelings. Troubles are lost in food (Saunders, 1985).

Binge eating also appears to be a normal part of college life for a significant number of women as a way of sublimating unpleasant affect states such as depression, anxiety and anger (Jones, 1989).

Elmore and de Castro (1990) have shown that binge eating reduces anxiety whether purging occurs or not. These recent findings raise the possibility that anxiety is reduced by

bingeing rather than, or in addition to, purging. Distress makes keeping the diet seem unimportant or unobtainable. The function of the binge-purge episode is to control or cope with external demands. If at any point they feel overwhelmed by external demands, they can call upon the structure of binge eating to organize their thoughts and behavior because of the highly ritualized and repetitive nature of the action. "Eating may provide a pleasurable experience, which, in the short run, minimizes the negative emotional experience" (Heatherton & Baumeister, 1991, p. 94).

Food may be used to avoid or cope with anger. Binge eating can be used as a strategy for taking one's attention off of other more threatening issues. Fairburn and Cooper (1987) stated that when control over eating is lost, the factors that promote overeating include the pleasure of eating "banned" foods, being a distraction from other current problems, and/or a vehicle for temporary alleviation of feelings of depression and anxiety (Heatherton & Baumeister, 1991).

Food is seen as a euphoric "high". Compulsive eaters often use food to avoid taking responsibility for problems. Food is perceived as a form of comfort or solace during stressful period. Food is viewed as a quick, simple solution

or distraction. Such compulsive eaters often use food to avoid their inherent limitations in life. Food can be used as a form of punishment to absolve guilt. Some clients use food as a way to "get back" at themselves for having done something wrong or to punish themselves. As a result they become locked in a behavior cycle of bingeing, guilt, and more bingeing (Schneider, 1990).

It is a symptom in the sense that the compulsive eater does not know how to cope with whatever underlies this behavior and turns to food (Orbach, 1978). Compulsive eaters use food for various reasons other than simply to provide fuel for their bodies. Some people often use food to comfort themselves when they are depressed or under stress. Recalling the pleasant sensations associated with food in their past, they now turn to it in an attempt to block out the pain they are experiencing. At times, food may be used as a temporary escape from boredom, loneliness, and a broad range of other negative feelings. Compulsive eaters misuse food to fill voids in their lives, to communicate their feelings, or to feel secure in certain situations (Landau, 1991).

"The obsession with food gives us a safe place into which we can place all our feelings of disappointment, rage, sorrow" (Roth, 1991, p. 63).

"We eat the way we live. What we do with food, we do in our lives. Eating is a stage upon which we act our beliefs about ourselves. As compulsive eaters we use food to somatize our deepest fears, dreams and convictions" (Roth, 1991, p. 103).

For bingers eating has lost its basic function of providing nourishment. Instead food has become a drug, producing good feelings and warding off bad ones. Relearning must take place, since patients have lost their ability to respond to the body's natural signs of hunger (Saunders, 1985).

Bulimia is a life-threatening condition. Bulimics who do not purge and who are overweight suffer from cardiovascular diseases - hardening of the arteries, heart enlargement, congestive heart failure, and hypertension - varicose veins, diabetes mellitus, cirrhosis of the liver and kidney disease. The psychological consequences are low self esteem, isolation, a sense of loss of control, guilt, demoralization, feelings of helplessness and depression. Most bulimics do report depression. A knowledge of the physical dangers does not appear to affect the compulsive eater's ability to control eating behavior. Many have tried to shock themselves into stopping, but cannot (Saunders, 1985).

This affirms that recovery for bulimics and compulsive overeaters is not achieved by gaining knowledge, being updated on the latest research information, fear of long-term physical damage or by others pressuring them to change to develop normal eating patterns. It's about feelings, about emotions and not wanting to cope with the root of their problems.

Chapter 3

Design of the Study

Procedures

Prior to the dissemination of the survey, permission and cooperation needed to be obtained by the Director of Housing at William Paterson College.

Permission was granted by Mr. Roland Watts, Director of Housing at William Paterson College during an in-person meeting. He suggested that I meet with Ms. Ann Wright, Director of Freshman Life and Ms. Maximina Rivera, Residence Director of the Towers. I met with them both, explained how I planned to proceed, and received their promise of support and full cooperation.

I was instructed by Ms. Rivera that my surveys must be disseminated through her office at the Towers. I had hoped that I would be allowed to pass out the surveys myself in order to ensure a successful return both quantitatively and qualitatively. I was informed that this was not possible.

I supplied Ms. Rivera's office with 200 surveys (corresponding with the number of freshmen females residing in the Towers), along with envelopes stamped "CONFIDENTIAL" to ensure the privacy of the respondents. I received a total of

16 returned surveys, 6 were disqualified due to incomplete responses.

Not being able to conduct a legitimate survey with 10 responses, I was forced to broaden the sampling by adding other New Jersey state colleges (Rutgers University, Stockton State College and Fairleigh Dickenson University). Another 20 surveys were disseminated by hand. Nineteen were returned.

Data Sources and Collection

Initially, one college dormitory had been chosen, William Paterson College Towers, Wayne, New Jersey. Due to the low response rate (16 out of 200), other sites were sought. Surveys were also delivered by hand by several volunteers to resident freshmen females at Rutgers University, New Brunswick, New Jersey; Stockton State University, Pomona, New Jersey; Fairleigh Dickenson University, Teaneck, New Jersey.

Treatment and Instruments Used for Data Selection

Surveys were distributed at William Paterson College by the office of Ms. Maximina Rivera, Director of the Towers. Others surveys at various other institutions were hand delivered by either myself or several volunteers. The sample was completely random with the restriction of being a freshman female residing on campus.

Surveys were filled out on a volunteer basis and could be completed in 10 to 15 minutes. See Appendix A for sample of the survey.

Chapter 4

Analysis of Data

The survey that was distributed to the resident college freshmen females consisted of eight items for personal data (age, ethnicity, high school grade point average, current grade point average, height, frame, weight in August of 1992, and weight in March 1993). Thirty six questions were posed to the women; fifteen of them were true/false; seven were short answer; three were based on a frequency scale; and the remaining eleven were check the most appropriate answer.

Of the 29 subjects the average age was 18.52. Nineteen were white, seven were black, one was hispanic, and two were asian. Seventy-six percent (22 respondents) of the entire sample had experienced a binge, seven subjects had not. Of those who binged, frequency of bingeing ranged from .002 to 5.5 times per week. The average was 1.49 binges per week.

The average high school grade point average of both bingers and total sample was the same: 3.35. Their current grade point averages were also nearly the same -- for bingers: 2.93 and for the total sample: 2.94.

Bingers are slightly smaller in frame and shorter than the total sample. Bingers averaged 61.28 inches and the total

averaged 62.58 inches in height. The bingers also averaged lighter in weight than the total sample. It is a great misconception that all bingers are overweight and gain weight more rapidly than non-bingers. Bingers come in all shapes and sizes. "Episodic overeating in the form of binges has been identified in subjects of all weight classifications from obese to anorexic" (Wardle, 1987, p. 48).

August 1992's weights ranged from 105 pounds to 173 pounds. March 1993's weights ranged from 105 pounds to 190 pounds. Weight gain for bingers averaged 3.68 pounds in seven months and 4.34 pounds for the total sample. Losses and gains ranged from -15 to +20.

Table 1

Percentage of bingers and non-bingers who gained or
lost weight

	Gain	Loss	Same
Bingers	73%	23%	4%
Non-bingers	71%	0%	29%

There is a slightly higher percentage of bingers who gained weight over non-bingers who gained weight. Twenty-nine percent of non-bingers had no weight fluctuation at all.

Table 2

Bingeing with whom?

RELATIONSHIP	PERCENTAGE
alone	59%
same friend	19%
any friends	11%
roommate	6%
family	5%

The majority of bingers binge alone and nineteen percent associate the same friend with their bingeing experiences.

Table 3

Most vulnerable time of day for a binge

TIME OF DAY	PERCENTAGE
morning	4.5%
afternoon	4.5%
evening	32%
late night	50%
between classes	0%
all the time	9%

Half of the respondents who binge find that late at night is the most vulnerable time for them. Evening is also a problem for many bingers. No one found bingeing between classes to occur at all. Nine percent of the bingers felt vulnerable to a bingeing experience all the time, regardless of the time of day.

Table 4

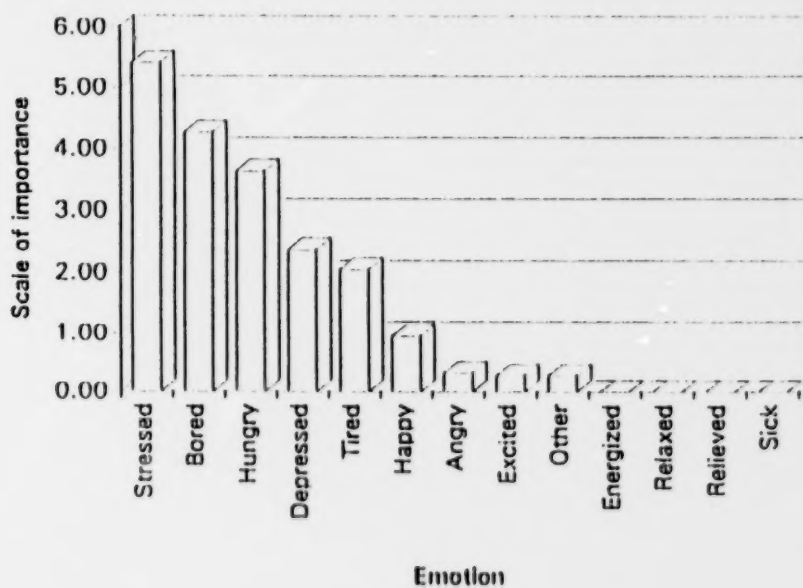
Location of binge

LOCATION	PERCENTAGE
kitchen	18%
in front of TV	32%
in bed	9%
at desk while studying	23.5%
in car	0%
cafeteria	6%
dorm room	9%
other	2.5%

Respondents chose more than one location. Percentages are representative from total number of various responses = 34. Bingeing in front of the television was the most popular response and eating at desk while studying ranked very high as well.

Table 5

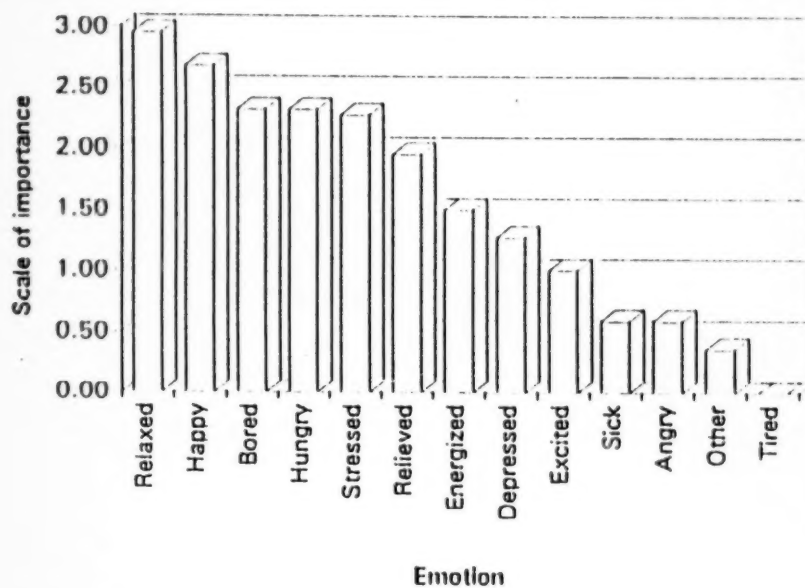
Feelings BEFORE a Binge



The emotion most often felt prior to a binge was stress. Next most often was boredom and third most often was hunger.

Table 6

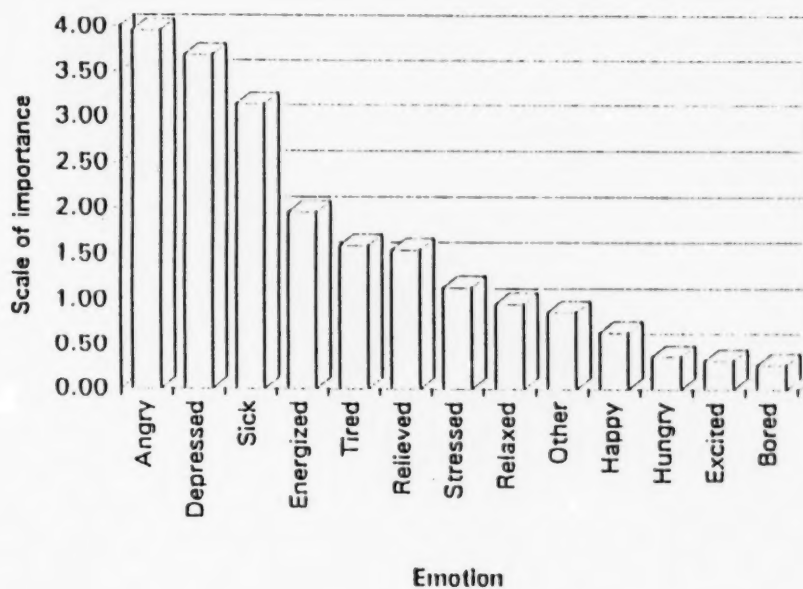
Feelings DURING a binge



A sense of relaxation was most commonly felt during a binge, followed by feeling happy, then bored on the frequency importance scale.

Table 7

Feelings AFTER a binge



Negative feelings overpowered the emotions felt following a binge. Anger felt most often, followed closely by depression. Third most often felt was a feeling of being sick.

Table 8

Compensation for bingeing and its relationship it weight gain

ACTION	TOTAL %	AVERAGE LBS. GAINED
do nothing	41%	+6
fast (not eat)	18%	-7
skip meals	4.5%	-11
exercise more	23%	+1.2
exercise intensely (over 3 hours)	4.5%	+12
vomit	4.5%	+15
take laxatives/diet pills/drugs	0%	0
keep busy	4.5%	+2

The majority of the respondents did nothing to compensate for their binges. Many used exercise in an attempt to set off weight gain. Eighteen percent of the women would fast or not eat to compensate for bingeing.

The figures of the average weight gain compared with compensation is not relative to action taken. The averages

are inconclusive due to the sample being too small.

Average pounds gained is segregated by each action taken.
Example: Of those bingers who "do nothing" to compensate for their binge, their average weight gain is 6 pounds.

Table 9

Smoking in relation to bingeing

FREQUENCY	BINGERS	NON-BINGERS
never	65%	100%
at parties	13%	0%
during exams	4%	0%
when stressed	4%	0%
all the time	9%	0%
once in the blue moon	4%	0%

None of the non-bingers smoke. Only nine percent of bingers smoke, but 13% smoke at parties.

Not included in this table is the statistic of those who did smoke, admitted to smoking an average of 1/2 pack per day.

Table 10

The relationship between those who gain weight and lose weight: their perception of stress and change in eating patterns

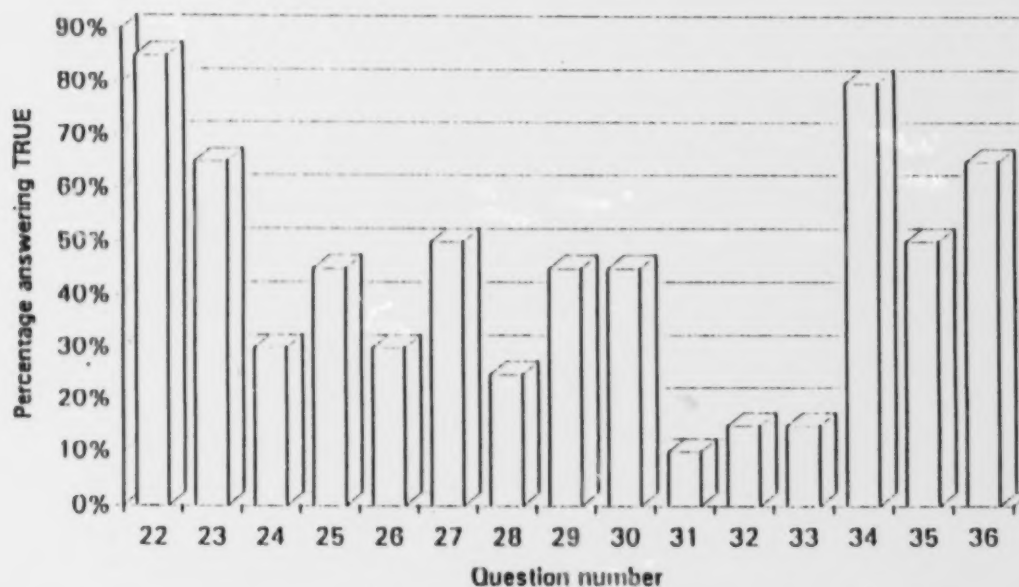
	GAINERS	LOSERS
college is more stressful	100%	14%
eating patterns have changed	73%	14%

Those women who gained weight over the seven month period of their freshman year, all admitted to finding college more stressful than high school. Nearly three-quarters of those who gained have experienced a change in their eating patterns.

The majority of those who lost weight their freshman year, have not changed their eating patterns and did not find college more stressful than high school.

Table 11

True/false



22. I binge more late at night.
23. I binge more on weekends.
24. I never binge at home.
25. I only binge alone.
26. I began bingeing in college.
27. I enjoy bingeing.
28. I can't without eating.
29. I feel totally control when I binge.
30. Once I start, I can't stop bingeing.
31. I have sought out help for compulsive eating.
32. I only binge during exams.
33. I associate bingeing with getting drunk/high.
34. I would never consider taking drugs to relax.
35. I hate myself after a binge.
36. I feel a sense of relief when eating.

Chapter 5

Summary and Conclusions

Problem Restatement

This study was constructed to examine the link of emotions to compulsive eating: before, during and after a binge episode, for resident college freshman females.

Description of Methods and Procedures Used

The methods used were research and survey. The research focused in on the following topics: the transition from high school to college, stress, coping mechanism, eating disorders, bulimia, purging versus non-purging, compulsive overeating, dietary restraints, a physiological, psychiatric and a cultural approach to bingeing and finally, the emotional link to binge eating.

The survey consisted of 36 questions in addition to a number of personal questions (ie. age, height, weight, etc.). The questions explored past eating behaviors with current eating behaviors, frequency, location and circumstances of binges, what time of day and where the subject has been most vulnerable to binge. The survey focused in particular to the feelings before, during and after a binge and how the subject

compensated, if she did at all. There was also a question to examine if the subject was a smoker to possibly link smoking with bingeing behaviors. The true/false section addressed a variety of bingeing situations.

Findings

Resident college freshman females are vulnerable to developing bingeing behaviors. Seventy-six percent have experienced a binge. Most freshmen resident females experienced a marked weight gain within the first seven months of living on campus. Seventy-nine percent have gained anywhere from 2 to 20 pounds. There is not necessarily a correlation between bingeing and weight gain. Non-bingers also gained weight. Interestingly, the non-bingers had a high percentage (29%) of subjects whose weight did not change. Consistently good eating habits accompanied with regular exercise prevent weight fluctuations.

Most bingers binge alone. The least common bingeing companion for the respondents was to binge with family. Bingeing has been known to be a very private activity, a time for oneself. Half of the group found late night their most vulnerable time to binge and most commonly in front of the

television or at their desk while studying. We could postulate that eating is being used as a form of relaxation in front of the television, or used as an escape from boredom or loneliness.

There is a very strong link between feelings, emotions and compulsive eating. By using a frequency scale of "1" being the most frequent, "2" being the next most often felt emotion, and "3" the third most often felt emotion, the respondents rated how the felt (in order of frequency) before, during and after a binge.

The predominant emotion felt before a binge was stress, next was boredom, and third was hunger. During a binge the most often felt emotion was relaxed, next was happy, and third was bored. After a binge negative feelings came on strong. The women's most often felt emotion following a binge was angry and following depressed was sick. These results are particularly important in the prevention and overcoming of compulsive eating. It is essential for compulsive overeaters to identify their feelings. Compulsive eating is not about food, it's about feelings. It is the feelings that trigger the eating when they're not physically hungry. If the subjects are aware that their bingeing behaviors lead to negative feelings, and they continue with this behavior, they

must ask themselves why.

The true/false questions revealed some interesting statistics. Only half of the women enjoy bingeing. Forty-five percent feel out of control when they binge, which is a dangerous precursor to developing bulimia. Forty-five percent also can't stop bingeing once they've started. Only a mere ten percent have sought out help for compulsive eating. Half of the respondents hate themselves after a binge and sixty-five percent feel a sense of relief when eating.

Conclusions

Seventy-six percent of the respondents to this survey have experienced a binge. I am not suggesting that these subjects are clinically bulimic, but I am suggesting that bingeing behaviors that may develop or have a forum to expose themselves in college can lead to a future of eating problems, which can be followed by destruction of self-esteem, interfering in these women's future achievements.

The higher incidence of disordered eating behaviors, distorted attitudes and poor coping mechanisms indicated by this and other studies predicates the importance of educating students about nutrition, normal eating behaviors as well as the prevalence of eating disorders. Most health classes' curricula do include the topics of anorexia nervosa and bulimia, but they customarily profile the extreme cases. It is important for students to realize that just because they aren't 98 pounds or aren't throwing up doesn't mean that they shouldn't examine their eating behaviors or what their relationship they've developed with food, how they use it to cope and why they eat compulsively.

Limitations of the Study

The study was limited to resident college freshmen women on the campus of William Paterson College of New Jersey. Two hundred survey were disseminated through the Towers' Residence Office.

Delimitations of the Study

Sixteen surveys were returned, 10 were useable for the study. The sample was then braodened to include other New Jersey schools: Rutgers University, New Brunswick; Stockton State College, Pomona; and Fairleigh Dickenson University, Teaneck.

The conclusions of this study can not be extended on a national basis. An extensive national survey is recommended.

Recommendations for Additional Studies

1. To reach the students who received this study, but did not respond due to the possibility that this topic is too sensitive.
2. A study applying behavior modification techniques, learning new coping mechanisms to stress and compare with a control group.

3. Explore family patterns and how they affect the development of healthy coping mechanisms, with particular examination of the relationship between mother and daughter.
4. Examine why women are more predisposed to these behaviors.
5. A study using peer group counseling sessions in a "safe" environment to explore compulsive eaters' feelings and emotions leading to their behavior.

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9. DID YOU HAVE ANY STRONG FOOD PREFERENCES AS A CHILD?
PLEASE DESCRIBE.

10. PLEASE DESCRIBE HOW YOUR EATING PATTERNS HAVE CHANGED
SINCE YOU'VE MOVED ON CAMPUS.

11. WHY?

12. PLEASE DESCRIBE WHAT YOU ENJOY EATING WHEN BINGEING.

13. HOW DID THIS BECOME YOUR FAVORITE BINGEING ITEM(S)?

14. HOW DO YOU FEEL BEFORE A BINGE?

(Please choose "1" for most frequently felt emotion, "2" for next most often, and "3" for third).

happy _____	angry _____
sick _____	tired _____
energized _____	excited _____
bored _____	depressed _____
stressed _____	relaxed _____
hungry _____	other _____
relieved _____	(please explain)

15. HOW DO YOU FEEL DURING A BINGE?

(Please choose "1" for most frequently felt emotion, "2" for next most often, and "3" for third).

happy _____	angry _____
sick _____	tired _____
energized _____	excited _____
bored _____	depressed _____
stressed _____	relaxed _____
hungry _____	other _____
relieved _____	(please explain)

16. HOW DO YOU FEEL AFTER A BINGE?
(Please choose "1" for most frequently felt emotion, "2" for next most often, and "3" for third).

happy _____	angry _____
sick _____	tired _____
energized _____	excited _____
bored _____	depressed _____
stressed _____	relaxed _____
hungry _____	other _____
relieved _____	(please explain)

17. HOW DO YOU COMPENSATE FOR BINGEING?
- a - do nothing
 - b - fast (not eat)
 - c - skip meals
 - d - exercise more
 - e - exercise intensely for over three hours
 - f - vomit
 - g - take laxatives
 - h - other (please explain) _____

18. DO YOU FIND YOURSELF THINKING ABOUT FOOD
- | | | |
|--------------------|-----------------|-------------------|
| _____ NEVER _____ | SOMETIMES _____ | ONLY AT MEAL TIME |
| _____ ALL THE TIME | | |

19. DO YOU SMOKE
- | | | |
|---------------------------|--------------------|--------------|
| _____ NEVER _____ | AT PARTIES _____ | DURING EXAMS |
| _____ WHEN STRESSED _____ | ALL THE TIME _____ | OTHER |

20. HOW MUCH DO YOU SMOKE?
- | | |
|---------------------------|----------------|
| _____ PACKS PER DAY _____ | PACKS PER WEEK |
| _____ PACKS PER MONTH | |

21. IS YOUR FIRST YEAR OF COLLEGE MUCH MORE STRESSFUL THAN HIGH SCHOOL? WHY OR WHY NOT?

TRUE/FALSE

22. _____ I BINGE MORE LATE AT NIGHT
 23. _____ I BINGE MORE ON WEEKENDS
 24. _____ I NEVER BINGE AT HOME
 25. _____ I ONLY BINGE ALONE
 26. _____ I BEGAN BINGEING IN COLLEGE
 27. _____ I ENJOY BINGEING
 28. _____ I CAN'T STUDY WITHOUT EATING
 29. _____ I FEEL TOTALLY CONTROL WHEN I BINGE
 30. _____ ONCE I START I CAN'T STOP BINGEING
 31. _____ I HAVE SOUGHT OUT HELP FOR COMPULSIVE EATING
 32. _____ I ONLY BINGE DURING EXAMS
 33. _____ I ASSOCIATE BINGEING WITH GETTING DRUNK/HIGH
 34. _____ I WOULD NEVER CONSIDER TAKING DRUGS TO RELAX
 35. _____ I HATE MYSELF AFTER A BINGE
 36. _____ I FEEL A SENSE OF RELIEF WHEN EATING

*This survey is being conducted by a graduate student at William Paterson College for her Masters' thesis. Your participation is greatly appreciated.

This survey is strictly confidential. Please use the envelope provided to ensure confidentiality.

Results of the survey will be made available through the Towers' Office the week of May 17 for all those interested.

Kindly return your surveys in the sealed envelope to your Resident Assistant as promptly as possible. Thank you for your cooperation.

If you have any further questions regarding the topic covered by this survey please feel free to contact Maximina Rivera in the Towers' Office for further information.

Appendix B

DIAGNOSTIC CRITERIA FOR BULIMIA

- A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).
- B. At least three of the following:
- (1) consumption of high-caloric, easily ingested food during a binge;
 - (2) inconspicuous eating during a binge;
 - (3) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting;
 - (4) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics;
 - (5) frequent weight fluctuations greater than ten pounds due to alternating binges and fasts.
- C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.
- D. Depressed mood and self-depreciating thoughts following eating binges.
- E. The bulimic episodes are not due to anorexia nervosa or any known physical disorder.

Source: American Psychiatric Association. (1980). Diagnostic and Statistical Manual of Mental Disorders (3rd ed.). Washington, DC, pp 69-71.

RISK FACTORS FOR DEVELOPING AN EATING DISORDER

INDIVIDUAL

- autonomy, identity and separation concerns
- perceptual disturbances
- weight preoccupation
- cognitive disturbances
- chronic medical illnesses (insulin-dependent diabetes)

FAMILY

- inherited biological predisposition
 - family history of eating disorders
 - family history of alcoholism, affective illness
 - family history of obesity (bulimia)

CULTURAL

- pressures for thinness
- pressures for performance

Source: National Institute of Nutrition. (1989, May/June). An Overview of the Eating Disorders Anorexia Nervosa and Bulimia Nervosa. Nutrition Today, 24(3), 27-29.